Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Integrated Care Programme for Older Persons

National Clinical
& Integrated Care Programmes
Person-centred, co-ordinated care

Submission to the Oireachtas Committee on the Future of Healthcare

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Executive Summary

Context

Older persons with complex care needs are among a cohort of patients considered 'high cost, high need' consumers with 5% of this population consuming up to 50% of health and social care resource (*Blumenthal, 2016). What sets older persons apart in terms of need is the combination of multiple chronic conditions (which increase with age) and social care needs. In that regard, addressing older persons needs simultaneously addresses the issue of chronic conditions.

Proposal

The Integrated Care Programme Older Persons (ICPOP) is a strategic initiative, reflective of international health policy. Working in tandem with the National Clinical Programme Older Persons (NCPOP), the ICPOP seeks to integrate the care of older persons (typically those considered as displaying frailty) with complex longitudinal care. It seeks to do this at three levels;

- Population planning
- Service planning and design
- Person centred care planning

A **10-Step Integrated Care Framework** represents the key steps necessary to facilitate a model of care based on integrated primary, secondary and community care.

This approach addresses key barriers by;

1. Incentivise existing examples of good practice that gets clinical and managerial buy- in.
2. Facilitating buy in by combining national enablers of integration (Seed funding and ICT enablers). Harnessing local innovative service initiatives, including the voluntary sector.

Key benefits

1. Older persons with long term complex care needs will have a single point of contact (case manager).
2. A case manager will help older people to access services when needed.
3. A multidisciplinary, community approach will be taken that provides a one stop shop for care coordination.
4. Beds in acute hospitals will be utilised for those who are in medical need.
5. Carers will be supported.
6. Technology will enhance care co-ordination through sharing of information.
7. There will be clearly defined pathways in hospitals with minimum lengths of stay.
8. More patients will stay at home or get back home more speedily.
9. Shift future model of care away from institutional care/long term care where possible.

Context and Overview

The Integrated Care Programme for Older People (ICPOP) and The National Clinical Programme for Older People (NCPOP) are leading out on the development of cohesive primary and secondary care services for older people especially those with more complex needs. The current focus is on the development of a number of pioneer sites nationally (seven), which includes building on the work on acute and mental health pathways developed by the NCPOP. These sites are already developing exciting initiatives that reflect new ways of working that puts the older person at the centre of care and adopt a population health approach to plan for needs locally. This is a core strategic initiative that will bring together those functions of healthcare delivery that enable integration such as ICT systems and workforce planning while being strongly informed by an evidence based approach on the needs of older people. This involves not only the development of high quality community and primary care services specific to older people but equally importantly, seamless integration with secondary services, underpinned by a culture of disease prevention, and promotion of health and wellbeing. The ultimate goal is to facilitate the older person to lead an independent life, with dignity and at home.

The NCPOP and ICPOP have formed the **National Working Group for Older People (NWGOP)** and are working in partnership with local providers, user and carer representatives, system enablers (finance, ICT) and policy makers (Department of Health) to deploy and test a framework to integrate care which puts at its core the need to support older persons to live well.

Service Risks

The large volume, rate of growth and complexity of illness in the older population, particularly in the +85 year olds, has put immense pressure on the acute & community system in the last few years and this growth is set to continue. The number of admissions on an emergency basis has increased across the age spectrum over 65, approaching 85% of all inpatient discharges in 2014. During 2014, almost 22% of all ED attendees were aged 65 or over, and almost 12.5% were aged 75 or over. In 2014, the proportion of attendees over 65s admitted for inpatient care increased by 20% from 32% in January to 38% in December 2014 (ED Taskforce Report, 2015).

Current increases in demand in home care services, day care services and voluntary supports and acute ED presentations have increased on a consistent basis nationally. Areas of particularly high volume of older people include Donegal, Cork, North Dublin and Galway. Areas of high growth rate in the 85+ age group include North Dublin, NW Dublin, SW Dublin and Cork City.

Older people represent those waiting longest on trolleys in ED, have the longest average length of stay (ALOS) and are the main reasons for delayed discharges experienced in the acute system in the last number of years. More adequately resourced integrated care pathways services for older people would result in reduced disease progression allowing people to live well in their own homes, reduced acute hospital stays and provide post-discharge support which in turn reduces the requirement for long term care (LTC.)

The risk of not addressing the increasing demographic and geographical pressures evident in recent years will result in;

- **Poorer outcomes including lessening the opportunity to live in ones' own home and community**
- **Increased inpatient LOS with older persons less likely to go home**
- **Increased cost of home support though a lack of early intervention**
- **Continued increase & worsening trolley numbers and PET times (increases inpatient LOS and reduced patient outcomes) which will become even more pronounced as the demographics continue to evolve.**

The increase in the older population in Ireland brings many opportunities and challenges (See Appendix 2 and NCP OP Oireachtas Submission (p.7). It is projected that the number of older people in Ireland will continue to increase throughout the coming decades. In 2011, 535,000 of the population were 65 years of age or older. This number is expected to increase by 60% in the next ten years and increase to 885,600 by 2026. The number of people aged 85 or over will increase to 116,300 by 2026 and represents a significant policy challenge given the combined impact of multiple co-morbidities and frailty.

Population Projections:

	2006	2011	2026
Total Population	4.2	4.6	4.8
≥65 yrs	467900	535400	885600
≥85 yrs	47800	**58400**	116300
In LTC			
5%	22613	**22341**	44255
4%			35404

Source: CSO

As older people have complex healthcare requirements, the Irish healthcare system needs to adapt to meet the demands associated with this demographic change. The large volume, rate of growth and complexity of illness in the older population, particularly in the +85 year olds, has put immense pressure on the acute & community system in the last few years and this growth is set to continue. Almost 22% of all hospital emergency department (ED) attendees are aged 65 and over and this age group account for 40% of all acute emergency medical admissions and 47.3% of total hospital bed days (HSE, ED Task Force Report, 2015, NCPOP, 2012).

Proposed framework for developing Integrated Care for Older Persons

The Programme for Government Policy, in recognition of increasing demographics (Working to make our older years better, P 84), outlines an integrated policy framework that seeks to address the social determinants of health through investment in transport, housing, finance (pension), reducing isolation, seven day services such as increased home help, and harnessing technology. This is consistent with priorities set out by the Secretary General (DOH, May 24th) in outlining how older persons are central to policy changes that simultaneously address ageing and the high prevalence of chronic disease and multi-morbidity as policy priorities.

The move towards an integrated model of older person's care across the continuum is in progress. Local and international evidence shows that providing services which address the specific needs of older people with complex requirements has positive dividends for the person and the system, reducing acute hospital use as well as length of stay and enabling the older person to continue living at home. It also includes important links to mental health services for older people which form a key support in managing the needs of older people in the community and form a key component of an integrated model of care.

The ICPOP and NCPOP are working closely on implementing an integrated model of care for older persons. This is based on a **10-Step Framework** and builds on existing work of the NCPOP and local good practice initiatives.

The ICPOP 10-step Framework for Older People (HSE, 2015) is designed to provide a conceptual map of integrated care. This map includes overarching functions required for integration, such as governance as well as enablers of integrated care, for example, ICT and MDT working. The framework also helps to illustrate the breadth of integrated care. This includes the need to have a population-based approach to planning as well as bespoke, evidence-based clinical pathways. This involves not only the development of high quality community and primary care services specific to older people but equally importantly, seamless integration with secondary services, underpinned by a culture of disease prevention, and promotion of health and wellbeing. At the centre of the framework is the fundamental need to support older persons to live well.

The NCPOP and ICPOP are working in partnership with local providers, user and carer representatives, system enablers (finance, ICT) and policy makers (DOH) to deploy and test the 10-step Integrated Framework for Older People to integrate care which puts at its core the need to support older persons to live well. The ultimate goal is to facilitate the older person to lead an independent life, with dignity and at home.

Approach - Incentivising the development of integrated services for older persons

1. The 10-Step ICP Framework sets out the desired direction of travel to integrate health and social care for older persons.

2. The emphasis on a population health approach requires Community Healthcare Organisation/Hospital Groups (and partners) to plan and implement a joint population planning approach to service development and delivery.

3. The CHO/Hospital Groups (and partners) will identify deficits in local services and submit for funding based on key criteria (substantively meeting the 10-Step Framework)

4. Bids for resource (seed funding) will also address local readiness and capability to deliver integrated care. This will demonstrate how new resources can complement and amplify

existing resource use in order to get the 'biggest bang for buck' from local older person services.

5. The ICP Structural evaluation will be used to consider the merit of further bids going forward (i.e. did areas deliver on previous financial and service commitment)

6. The ICP Steering Group will oversee this process and will be accountable to the national governance structure.

In 2016, development funding of €1.7m was allocated to ICPOP in order to commence the foundational steps towards integrated care for older persons. The key deliverables included establishing local and national governance and recruiting clinical posts to become a catalyst for integration locally. A core component of the ICPOP approach is to leverage existing community resources in the local health ecosystem. These include acting as a conduit to and co-ordination of care in tandem with social care providers (public and private), community intervention teams, day hospital, day care, community intervention teams etc.

Build incrementally and test outcomes using a multi annual approach

- The ICPOP/NCPOP advocate a multi annual approach that seeks to build the foundations of integrated care incrementally.
- This seeks to move at a scale and pace that is organisationally realisable in terms of enabler such as ICT and workforce development.
- This incremental approach is founded on a core focus on evaluation of structure (governance and teams in place), process (measuring care processes, transitions between care) and outcome (patient centred outcome measures and value based care).

In that regard, a 3-year time frame for funding is outlined below. This is linked with a corresponding set of work streams to demonstrate proof of concept.

Year	No of additional wte	WTE (Grouping)	WTE Descriptor	**Total €m (inc non pay)**	**No of teams (total)**	No. of HNHC Older Persons Benefitting
2016	**35.0**	Clinical	HSCP (CNM, Consultant Geriatrician, AHP, HCA)	**2,604,383**	***7**	**17,500**
2017	**24.0**	Clinical	HSCP (CNM, Consultant Geriatrician, AHP, HCA)	**2,200,784**	**11**	**27,500**
2018	**24.0**	Clinical	HSCP (CNM, Consultant Geriatrician, AHP, HCA)	**2,200,784**	**16**	**40,000**

2019	**24.0**	Clinical	HSCP (CNM, Consultant Geriatrician, AHP, HCA)	**2,200,784**	**20**	**50,000**

Benefits

1. Older persons with long term complex care needs will have a single point of contact (case manager)
2. A case manager will help older people to access services when needed
3. A multidisciplinary, community approach will be taken that provides a one stop shop for care coordination
4. Beds in acute hospitals will be utilised for those who are in medical need
5. Carers will be supported
6. Technology will enhance care co-ordination through sharing of information
7. There would be clear defined pathways in hospitals with minimum lengths of stay
8. More patients staying at home or getting home more speedily
9. Shifting a model away from institutional care/long term care where avoidable

Conclusion & Key Message

- The ageing population is testament in part to improved healthcare in Ireland and is to be welcomed.
- A policy context that includes and goes beyond health care is critical for enabling older people to live well in their own homes and communities.
- The implementation of reform within health and social care systems should recognise the needs of older people (particularly those with multiple conditions) as unique, requiring a broad multiagency approach.
- Systems that are designed for older people should be in place across the care journey and should recognise and meet their complex healthcare needs. This includes new roles and ways of working.

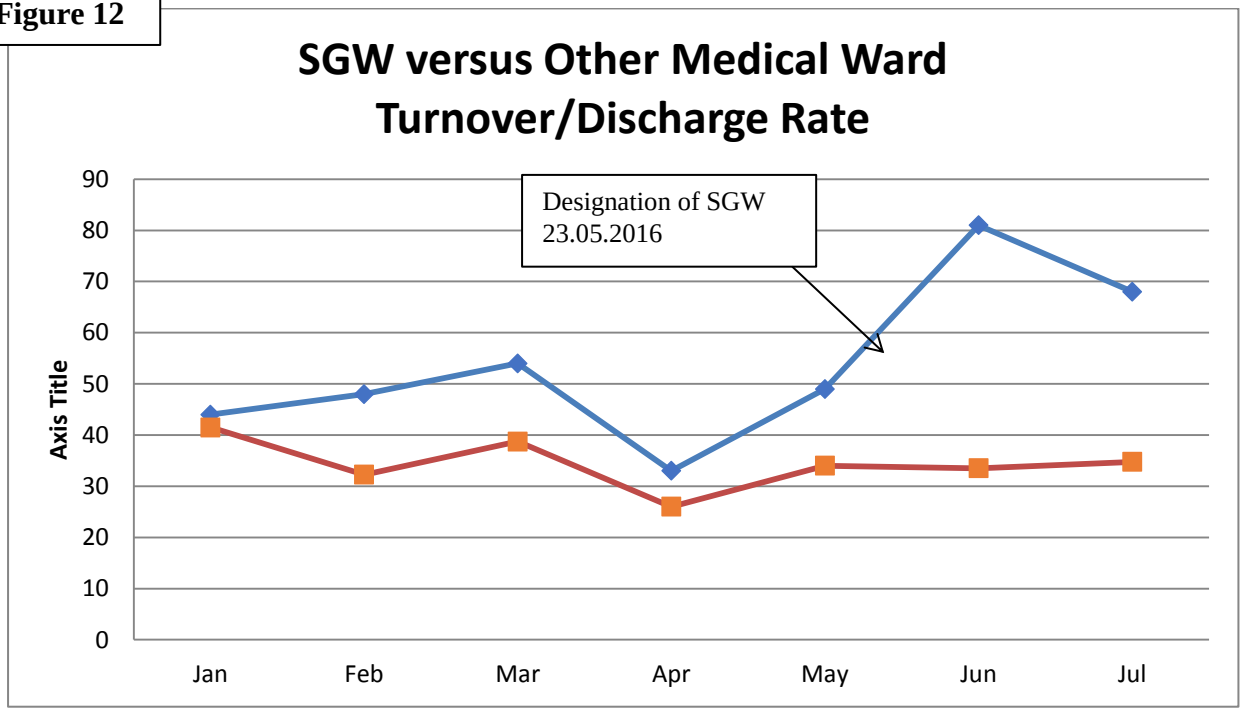
Appendix 1

Implementing an acute older person pathway in Sligo General Hospital (SGH)

Funding from ICPOP/NCPOP facilitated the development of an acute care pathway in SGH. This has resulted in

- Increased discharges by 63% thus providing more capacity
- Reduced length of stay by 22% (3 day) from 12.6 to 9.7 days

Figure 12



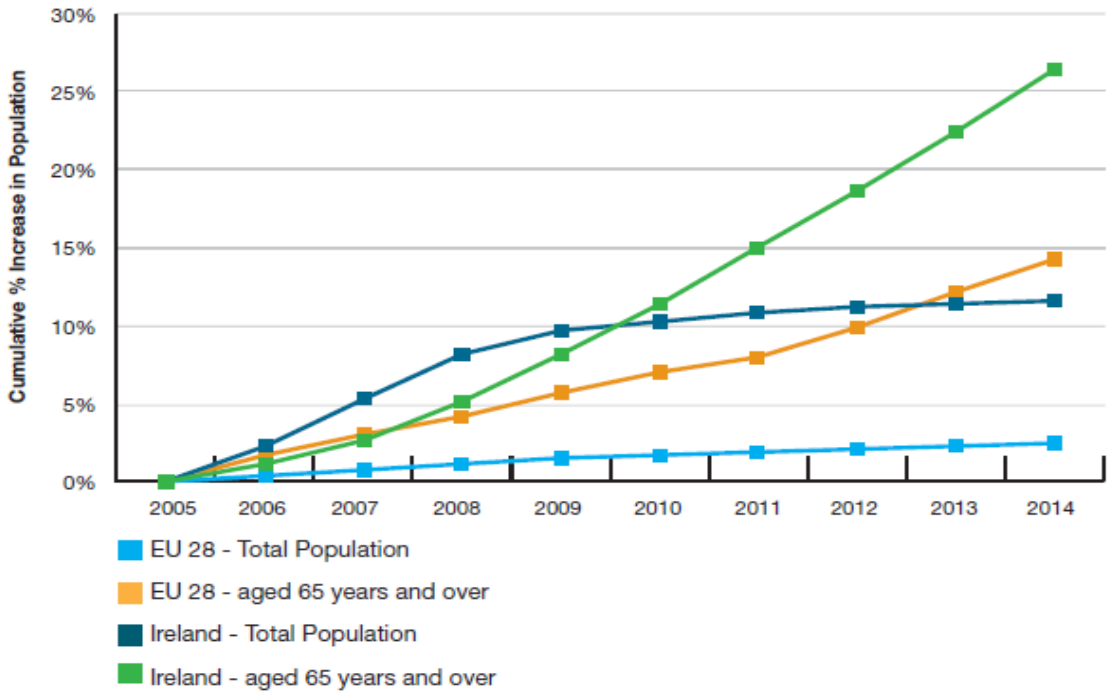
From January to May, the median number of discharges for this ward per month was 48 patients. Since the designation of the ward this increased to 74 patients per month (an increase of 63%). The discharge rate of other comparable medical wards has remained relatively constant at 34 patients per month.

Appendix 2

Population Growth of Older People in Ireland

It is important to understand demographic trends when estimating the need for health services. The Department of Health (Health in Ireland, Key Trends December 2015) has highlighted that the over-65s are increasing at a faster rate in Ireland compared to most other EU countries.

FIGURE 1.2
CUMULATIVE PERCENTAGE INCREASE IN POPULATION, ALL AGES AND 65+, IRELAND AND EU 28, 2005 TO 2014



Source: Eurostat.